REQUEST for STAKEHOLDER COMMENT
Design and Development of an Insurance Exchange in Connecticut

The following information is organized by general topic area, with a list of questions we would like you/your organization to answer as you feel appropriate. These questions are followed by background briefings to provide a general understanding of the topics. To encourage productive discussion during each meeting, we are providing you this information in advance of your meeting. While these topic areas are the specific issues for which public comment is requested, please feel free to offer any other comments on policies related to the Exchange and the insurance market as well.

This information is submitted from:

Name: Linda Erlanger, DDS Phone: 860-246-2644, ext 202

Organization: Connecticut Oral Health Initiative (COHI) Email: lindae@ctoralhealth.org

Address: 175 Main St, Hartford, CT 06106

QUESTIONS

Please provide us with your thoughts and insights on the questions listed below as you feel appropriate.

A. Establish a Responsive and Efficient Structure

1. Should Connecticut consider joining a multi-state Exchange? Under a regional Exchange, would Connecticut benefit most from a separate or merged risk pool?
    a. CT should benefit from participation in a multi-state Exchange in order to spread the administrative expenses, e.g. IT, call center, claims review, across a richer expanse of resources. As well, enrollees who live close to neighboring state lines would have an expanded provider network in which to receive services (in some bordering communities, the provider network may be thin)
    b. Because state rules and benefits may vary, a shared risk pool may not be logical or easy to administer and manage. Also, there are potential issues of one state actually funding, or subsidizing, residents of other states in the risk pool thereby creating greater financial strain for one state and easing the burden of others.

2. Should Connecticut administer the Exchanges for the individual and small group markets separately or jointly? If jointly, should Connecticut maintain separate risk pools for the two Exchanges, or merge the risk pools.
    a. Joint administration of individual and small group market makes sense. Efficiencies can be created through streamlined administrative processes.
    b. Merge the risk pool.

3. Should Connecticut open the Exchange to businesses with 2-100 employees in 2014, or should it allow businesses with 2-50 employees in 2014 and increase participation to businesses with 51-100 employees in 2016?
    a. Wait and see approach. The Exchanges are new entities and it may be more conducive to start in the smaller market, work out the process and procedure issues with a smaller enrollee population, and then build on that experience before increasing Exchange membership.

4. Should Connecticut seek to expand access to businesses with more than 100 employees in 2017, with HHS approval?

B. Address Adverse Selection and the External Market

1. Should Connecticut allow a dual market, a hybrid market, or should it require that all individual insurance be sold through the Exchange? Under a dual market scenario, what additional rules should Connecticut establish to prevent insurers from discouraging participation in the Exchange? What hybrid models might Connecticut consider, and what characteristics do they offer that would benefit Connecticut?

2. Are there any additional mechanisms to mitigate adverse selection that Connecticut should consider implementing as part of the Exchange?

3. How should the temporary reinsurance program be approached in Connecticut? What issues should Connecticut be aware of in establishing these mechanisms?

C. Simplify Health Insurance Purchase

1. What issues should Connecticut consider in establishing a Navigator program?
    a. Navigators should be able to advise on all options in the Exchange, including medical, dental, behavioral health, etc. Consumers from all aspects of our population are often confused about their dental benefits (if they even have them at all). The Navigator program must provide information that is linguistically and culturally appropriate. Hopefully, that information extends to Navigators providing a basic understanding of dental terminology and procedures to enable them to more effectively educate and guide applicants in the plan selection process and beyond.

2. What should Connecticut consider regarding the role of insurance brokers and agents?

D. Increase Access to and Portability of High Quality Health Insurance

1. Should Connecticut allow any plan that meets Qualified Health Plan standards to be available in the Exchange, or should Connecticut establish additional requirements? If additional requirements, what would you recommend? What would be impact of those requirements?
    a. The ACA stated some level of standards that health plans must attain and maintain in order to be invited into the Exchange and to remain there. CT must consider extended hours for the call center, as well as 24 hour access to verify eligibility, benefits, health information, e.g. web site, IVR. Also, requirements should include a skilled care coordinator to patient ratio that meets or exceeds the benchmarks for this measure.

2. Should Connecticut consider establishing the Basic Health Program? What would the Basic Health Program offer as a tool to facilitate continuity of coverage and care?
    a. Yes, it should consider establishing the Basic Health Program
    b. Skilled Navigators and Care Coordinators can facilitate continuity of coverage and care

3. How would the Basic Health Program impact other related programs in Connecticut?

4. How can Connecticut structure its Exchanges to maximize continuity of coverage and seamless transition between public and private coverage? (E.g. as a person moves from Medicaid, subsidized and non-subsidized markets)

E. Ensure Greater Accountability and Transparency

1. What information should Connecticut include for outreach to most effectively engage consumers? How should the information be presented?
    a. There is a general lack of knowledge about the costs of health care, e.g. outpatient services, hospitalization, lab tests, chronic care treatment, etc. If there is an effective way to present these expenses that informs consumers and helps them be more engaged in their health care decisions as they relate to expenses, then the Exchange should do it.

2. How should Connecticut ensure ongoing feedback and input about accountability, operational issues, and suggested improvements?
    a. Surveys are not always so effective for these issues. Direct, ongoing discussions with Exchange enrollees and Exchange employees and an "open door" policy on sharing positive and negative feedback is essential.

3. What information, beyond that required under the ACA and implementing regulations, should Connecticut require of plans? How much of this information should be shared with consumers accessing the Exchange?

F. Self-Sustaining Financing

1. How should the Exchange's operations be financed beginning in 2015?

2. How might the state's financing strategies encourage or discourage participation in the Exchange; affect the reputation of the Exchange; and affect accountability, transparency, and cost-effectiveness?

3. What issues should be considered regarding state requirements for additional benefits above the minimum essential benefits? What funding sources should be considered for the cost of additional benefits?
    a. If one looks at plan coverage and financial expectations, the current model for general medical services differs significantly than for oral health services. For example, an individual who has already exceeded $1000 in annual medical health plan paid expenses presents to a physician's office for treatment of what turns out to be the common flu. The patient either receives coverage in full by the health plan for the visit or is responsible for some level of cost-sharing, or copay. If the same individual has also exceeded $1000 in annual expenses paid by the dental plan and presents to a dentist's office with an infected tooth, the patient is fully responsible for the visit charges. (This assumes that the patient has a $1000 annual coverage maximum found in a majority of dental plans).

       This discrepancy of plan coverage between medical and dental services has existed far too long. The maximum coverage for dental services creates a barrier to access for many people who often cannot afford the cost of treatment of an infection in their body, in this case a tooth. QHPs and other plans, which should be required to offer dental coverage to children and adults in the Exchange, must address this existing payment maximum by eliminating it altogether or increasing it to a more reasonable amount, e.g. $5000 annually

G. Under the ACA, an Exchange is responsible for performing a specified list of functions. However, many decisions are left to the states.

1. Beyond the Exchange's minimum requirements, are there additional functions that should be considered for Connecticut's Exchange? Why?

2. Are there advantages to limiting the number of plans offered in the Exchange, or is the Exchange a stronger marketplace if it permits "any willing provider" to sell coverage?

    a. Limiting the number of plans doesn't make total sense if CT eventually wants most state residents to purchase through the Exchange. It seems better to offer a full array of options from a competitive perspective and for greater consumer choice. If "any willing provider" is able to meet or exceed the requirements to participate effectively in the Exchange, then consider them eligible to offer their services.

3. Should Connecticut consider setting any conditions for employer participation in the small group exchange (e.g. minimum percent of employees participating, minimum employer contribution, limits in the range of product benefit values that may be selected by employees, etc)?

4. What are some of the initiatives that could maximize flexibility and offer a value for small business employers to utilize the Exchange?

5. What should be the role of the Exchange in premium collection and billing?

6. What are all the different data collection and reporting mechanisms that are necessary to operate a transparent and accountable Exchange?

BACKGROUND by TOPIC AREA

The general information on each topic area below is intended for brief reference only.

A. Establish a Responsive and Efficient Structure

The ACA requires that all states establish an American Health Benefits Exchange for the individual market and a Small Business Health Options Program (SHOP Exchange) for the small group market. States may operate these independently or may combine them into a single Exchange. States may also form regional or multi-state Exchanges.

For the purpose of inclusion in the SHOP Exchange, the ACA defines small employers as an employer with 2-100 employees. However, until 2016, states may limit this definition to 2-50 employees; and after 2017 states may further expand participation in the SHOP Exchange.

B. Address Adverse Selection and the External Market

The ACA allows states to establish a "dual market" in which individual insurance may be purchased in and out of the Exchange, or to require that all health insurance plans sold on the individual market must be sold through the Exchange. States may also design "hybrid" solutions such as permitting supplemental coverage to be sold in external markets but requiring that all individual major medical coverage be sold in the Exchange.

The ACA establishes certain rules to protect against selection issues in a dual market, but does not deny states the ability to include additional requirements for insurance sold in the Exchange and an external market. State options include but are not limited to requiring that all insurers in the Exchange offer all four tiers of coverage, standardizing benefits packages, and restricting the sale of "catastrophic" insurance plans. However at a minimum, the following rules apply:

- Plans inside and outside of an Exchange must be in the same risk pool, have the same premium rate (for those sold by the same company), and meet the same minimum benefits standards.
- Insurers inside and outside the Exchange may not deny coverage on the basis of pre- existing conditions, medical status, or claims history.
- Premium variation based on age, geographic location, and smoking status must apply to plans sold both inside and outside the Exchange.

- Plans sold in the Exchange must have an open enrollment period and special enrollment periods to encourage participants to purchase coverage before they become sick.

The ACA requires that states establish a reinsurance program for the individual market inside and outside of the Exchange, for the first three years of Exchange operation. The NAIC will develop model legislation to carry out this provision. States must consider issues such as how to coordinate their high risk pools with this program.

C. Simplify Health Insurance Purchase

The ACA requires an Exchange to establish a "Navigator" program to conduct public education, advise individuals and small groups that enroll in the Exchange, help them enroll in health plan and access benefits, and provide referrals as needed to the health care ombudsman. The Navigator program must be established by awarding grants to a variety of groups, and must be financed through operational funds of the Exchange (not Federal funds received by the state to establish the Exchange).

With establishment of an Exchange, the existing relationship between brokers, carriers, and consumers is likely to change. The ACA leaves states flexibility to make decisions regarding these relationships, such as designating an official role for brokers within the Exchange apparatus, requiring certification, or regulating commissions.

D. Increase Access to and Portability of High Quality Health Insurance

The ACA requires that health plans that wish to participate in an Exchange (Qualified Health Plans) comply with certain requirements related to marketing, choice of providers, plan networks, and essential health benefits. Beyond this, states may establish additional requirements for plans that are offered on an Exchange.

The ACA provides states with the option of operating a Basic Health Program for individuals between 133% and 200% of the federal poverty level, in lieu of those individuals receiving premium subsidies for purchase of coverage. The benefits under the Basic Health Program must be at least equivalent to the essential health benefits and premiums may not be higher than those in the Exchanges.

With health care reform, individuals may be eligible for one of a variety of insurance options: Medicaid, CHIP, subsidized coverage through an insurance Exchange, and unsubsidized coverage through an Exchange. The ACA requires that there should be a single seamless process of applying for coverage for all of these programs – regardless of where a consumer enters the system.

E. Ensure Greater Accountability and Transparency

The ACA requires that Exchanges post information on the cost and quality of health plans. Specifically, states must develop an Internet website for standardized comparative information on plans, provide public ratings of participating Exchange plans, and use a standard format for presenting health plan options in the Exchange.

F. Self-Sustaining Financing

The ACA includes grant funding for planning and establishment of Exchanges, but beginning January 1, 2015, state Exchanges must be financially self-sustaining.

The ACA establishes a minimum essential benefit set to be sold inside and outside an Exchange. A state may choose to require additional benefits but must cover the cost of those benefits for individuals eligible for tax credits through an Exchange.

G. Under the ACA, an Exchange is responsible for performing a specified list of functions. However, many decisions are left to the states.

Under federal law, the Exchange is required to perform these functions:

- Certify, recertify, and decertify qualified health benefits plans under the guidelines established by the federal Department of Health and Human Services (HHS)
- Operate a toll-free customer assistance hotline
- Maintain a website that allows customers to compare qualified health benefits plans offered by different insurance carriers
- Assign a rating to each qualified health plan under the rating system that will be established by HHS
- Use a standardized format to present four coverage options (bronze, silver, gold, and platinum), plus the catastrophic plan design for young adults/exemptions
- Inform individuals about the existence of—and their eligibility for—public programs, including but not limited to Medicaid and Children's Health Insurance Program (CHIP)
- Certify individuals who are exempt from the individual mandate on the basis of hardship or other criteria to be established by HHS
- Transfer information to the federal Secretary of Treasury regarding individual mandate exemptions and subsidies awarded due to a failure on the part of a small employer to provide sufficient affordable coverage
- Provide information to employers on their employees who are not covered
- Establish a network of navigators to raise awareness among customers of their coverage options and to help people select and enroll in health plans and subsequently access benefits